

MEDICARE AND PRIVATE HEALTH INSURANCE

A TRAINING TEXT

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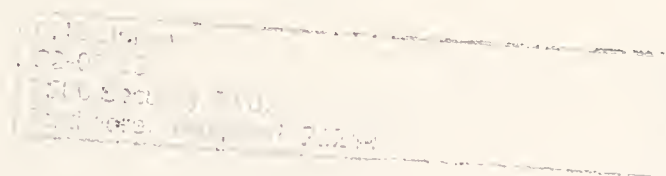
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MEDICARE AND PRIVATE HEALTH INSURANCE

A Training Text



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Introduction

Medicare covers many of the health care expenses most elderly Americans face, particularly for hospital care and doctors' services. These costs are so high that lack of Medicare insurance protection could lead to serious financial problems when the services are needed. But Medicare does not cover these services in full and there are a number of less expensive, but often necessary, health care services which Medicare only partly covers or does not cover at all.

For this reason, many private insurance companies offer health insurance to supplement Medicare. This insurance provides coverage to fill some of the gaps in Medicare. Deciding whether to buy private health insurance and choosing what kind is best suited to your individual situation are important, and not always easy, judgments to make.

This training text has been prepared by the Health Care Financing Administration, the Federal agency that administers the Medicare program, to give you information that will help you make the

decision as to whether you need additional health insurance, what kind of health insurance might be best for you and what kinds of misleading sales practices you should be alert to.

Although we believe that study of this booklet will help you to be a better informed and a more careful purchaser, we recommend that you seek the advice of others before you buy. It is an important decision and getting a second opinion may be very helpful to you. If you have a knowledgeable friend or relative, or are a member of a senior citizens' organization, or if there is a Senior Citizen Center or Consumer Protection Agency or Legal Services for the Elderly organization in your area, these are resources you may wish to use. In addition, the State Insurance Department of your State Government is a resource you can always draw on and many of them have prepared information material on private health insurance that they will be glad to give you.

What Medicare Covers

BASIC PROVISIONS

Medicare is two separate programs—Hospital Insurance (sometimes called Part A) and Medical Insurance (sometimes called Part B).

Hospital insurance covers inpatient care in a hospital, inpatient care in a skilled nursing facility after a hospital stay, home health care, and hospice care.

Medical insurance covers doctors' services, outpatient hospital services, home health services and a number of health

care services, such as X-ray and laboratory services, ambulance services, physical therapy, and rental or purchase of durable medical equipment.

You can tell what Medicare coverage you have and when it began by examining your Health Insurance Card, which shows this information. If you only have one part of Medicare, you can get information about getting the other part from any Social Security office.

What Medicare Covers

MEDICARE HAS TWO PARTS:

- **Hospital Insurance (Part A)**

Inpatient Hospital Care
 Post-Hospital Skilled Nursing Facility Care
 Home Health Care
 Hospice Care

- **Medical Insurance (Part B)**

Doctors' Services
 Outpatient Hospital Services
 Home Health Care
 Other Health Care Services

This shows whether you have hospital insurance only, medical insurance only, or both. ➡

Health  Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY	
CLAIM NUMBER	SEX
IS ENTITLED TO	EFFECTIVE DATE
Hospital Insurance	1-1-82
Medical Insurance	1-1-82
SIGN HERE 	

What Medicare Covers

HOSPITAL INSURANCE — BENEFIT PERIODS

Two benefits under Medicare's hospital insurance program—inpatient hospital care and skilled nursing facility care—are paid on the basis of *benefit* periods. Special limited benefit periods apply to hospice care (see page 18).

A benefit period *begins* when you enter a qualified hospital and ends when you have been out of a hospital or skilled nursing facility for 60 consecutive days. Then a new benefit period can begin the next time you enter a hospital. There is no limit to the number of benefit periods you can have, but after one benefit period begins, a new one cannot start

until you have not been an inpatient in a hospital or skilled nursing facility for 60 days in a row.

Within *each* benefit period, Medicare hospital insurance can cover up to 90 days of inpatient hospital care and up to 100 days of inpatient skilled nursing facility care. Regardless of how many days you use in one benefit period, the full amounts are restored each time a *new* benefit period begins.

There is no limit to the number of medically necessary home health visits you can receive under Medicare hospital insurance.

What Medicare Covers

HOSPITAL INSURANCE

Benefit Periods

- *Begin* when you enter a qualified hospital
- *End* when you're out of a hospital or skilled nursing facility for 60 days in a row
- No limit to the *number* of benefit periods

What Medicare Covers

HOSPITAL INSURANCE — WHEN YOU ARE A HOSPITAL INPATIENT

In each benefit period, you are entitled to as many as 90 days of inpatient hospital care in any hospital that participates in Medicare. Almost all hospitals in the U.S. do participate.

For the first 60 days of inpatient hospital care in a benefit period, you are responsible for the first \$400 of expenses. This is called the *inpatient hospital deductible* and is charged only once in each benefit period. Except for this deductible, and the charges for noncovered services, such as telephone, television or a private room that is not medically necessary, Medicare hospital insurance pays for all the covered services you receive during your first 60 days of inpatient hospital care in each benefit period.

For the 61st through the 90th day of inpatient hospital care in each benefit period, Medicare hospital insurance will pay for all covered services except for \$100 a day.

If you ever need to use more than 90 days in a benefit period, see pages 12

and 13 for a description of your hospital "reserve" days.

The 90 days of inpatient hospital care in each benefit period do not have to be consecutive. For example, if you are in a hospital for 10 days and are then discharged, you would have 80 days that you can still use in that benefit period. If you stay out of a hospital or skilled nursing facility for 60 days in a row, of course, then a new benefit period starts the next time you enter a hospital and your full 90 days are reinstated. You must pay a new deductible for each new benefit period.

The deductible and copayment amounts shown in this book for inpatient hospital services and skilled nursing facility services are subject to change at the beginning of each calendar year. The amounts shown in this book are for calendar year 1985. You will find additional information about deductibles and copayments under Medicare on page 28.

What Medicare Covers

HOSPITAL INSURANCE

When You're A Hospital Inpatient

- 90 days per benefit period
First 60 days—You pay \$400*, *Medicare pays the rest.*
61st through 90th day—You pay \$100* a day.
Medicare pays the rest
- Covered Services: semi-private room, all meals, general nursing care, drugs, lab services, x-rays, operating and recovery room, special care units, anesthesia services and rehab services

*(1985 Amounts)

What Medicare Covers

HOSPITAL INSURANCE—INPATIENT RESERVE DAYS

The average inpatient hospital stay for Medicare beneficiaries is 10 days. For the great majority of beneficiaries, the 90 days of inpatient hospital care they are entitled to in each benefit period will cover all the inpatient hospital care they will ever need in their lifetime. Even if, on occasion, they have an above average hospital stay of, for example, 40 or 50 days, as soon as they are out of a hospital or skilled nursing facility for 60 days in a row, a new benefit period can begin and the original 90 days of inpatient hospital care can start over again. So, for most beneficiaries, Medicare hospital insurance is almost total protection against covered inpatient hospital care costs.

But, now and then, a beneficiary may need more than 90 days of inpatient hospital care in a benefit period. For that reason, Medicare hospital insurance provides 60 additional inpatient hospital days that can be drawn from whenever more than 90 days is required in a benefit period. These 60 days are called "reserve" days. This means that you can have as many as 150 covered days of inpatient hospital care in a benefit period. But once you use them, "reserve" days are not replaced when a new benefit period begins.

For each "reserve" day used, Medicare pays for all covered services except for \$200 a day (for 1985).

What Medicare Covers

HOSPITAL INSURANCE

Inpatient Reserve Days

- 60 hospital days that can be used if more than 90 days of inpatient hospital care are needed in a benefit period
- Cost you \$200 each to use (1985 amount)
- Used "reserve" days not replaced when new benefit period begins

What Medicare Covers

HOSPITAL INSURANCE — WHEN YOU ARE IN A SKILLED NURSING FACILITY

Sometimes people who are receiving care as hospital inpatients reach the point in their treatment when they no longer need the intensive—and expensive—care furnished by a hospital, but are not well enough to go home. They still need skilled nursing or skilled rehabilitation services on a daily basis which, as a practical matter can only be provided as an inpatient in a skilled nursing facility. The Medicare benefit is designed to provide such care for the acute post-hospital patient, but it is not long-term care protection.

Medicare hospital insurance provides for up to 100 days of post-hospital care in a participating skilled nursing facility for beneficiaries whose medical condition requires a skilled level of care and who also meet certain other requirements. For the first 20 days of care in a skilled nursing facility in each

benefit period, Medicare hospital insurance pays for all covered services. From the 21st through the 100th day, Medicare hospital insurance pays for all covered services *except for* \$50 a day (for 1985).

Most “nursing homes,” as that term is generally understood, are *not* skilled nursing facilities and, therefore, no Medicare benefits are available in such “nursing homes.” Medicare covers care only in a participating skilled nursing facility and only when the care being furnished is reasonable and necessary for the further treatment of a condition that was treated during the patient’s hospital stay. Medicare does not cover care which is mainly custodial—that is, care which is primarily needed to help in meeting personal care needs, such as eating, dressing, using toilet facilities and taking routine medication.

What Medicare Covers

HOSPITAL INSURANCE

When You Require Covered Care In A Skilled Nursing Facility

- Up to 100 days per benefit period
First 20 days—Medicare pays for all covered services
21st through 100th day—You pay \$50 per day, Medicare pays the rest (1985 amount)
- Covered Services—include semi-private room, meals, general nursing care, drugs, rehab services, medical supplies and equipment

NOTE:

- Most nursing homes are NOT skilled nursing facilities
- Medicare does NOT cover custodial care

What Medicare Covers

HOSPITAL INSURANCE — WHEN YOU RECEIVE HOME HEALTH SERVICES

Sometimes people are confined to their homes because of an illness or injury and need skilled health services only on a part-time basis. In some cases these services may be medically necessary after a hospital stay or after receiving care in a skilled nursing facility. In other cases, periodic visits by skilled nurses or physical or speech therapists in your home could help you avoid an inpatient stay.

To help meet this need, Medicare hospital insurance covers all medically necessary home health visits when

skilled nursing and other therapy services are furnished by a home health agency participating in Medicare. Medicare pays the full reasonable costs for these visits. You have no deductible or copayment for home health services. The services must be furnished under a medical treatment plan supervised by your doctor. Medicare does not cover homemaker or other services which are primarily offered to assist you, such as help with dressing, bathing, eating, housekeeping and shopping.

What Medicare Covers

HOSPITAL INSURANCE

When You Receive Home Health Services

- Home Health Visits—Medicare pays all
- Covered Services—part-time skilled nursing care, physical therapy, speech therapy

If you need any of the above services: also covers part-time home health aide services, occupational therapy, medical social services, medical supplies and equipment

What Medicare Covers

HOSPITAL INSURANCE— HOSPICE CARE

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Medicare hospital insurance can help pay for hospice care if all of the following three conditions are met: (1) a doctor certifies that a patient is terminally ill, (2) a patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness, and (3) care is provided by a Medicare-certified hospice program.

Special benefit periods apply to hospice care. Hospital insurance can pay for a maximum of two 90-day periods and one 30-day period. (If a patient still needs hospice services after hospice periods are exhausted, the hospice must continue care unless the patient no longer wants hospice services.)

During a hospice benefit period, Medicare pays the full cost of all covered ser-

vices for the patient's terminal illness. There are no deductibles or co-payments except for part of the cost of outpatient drugs and inpatient respite care.* The patient is responsible for 5 percent of the cost of outpatient drugs or \$5 toward each prescription, whichever is less. Also, the hospice can charge the Medicare patient 5 percent of the cost of inpatient stays for respite care.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

*Respite care is a short term inpatient stay which may be necessary in order to give temporary relief to the person who regularly assists with the patient's care. Inpatient respite care is limited to stays of no longer than five consecutive days in a row.

What Medicare Covers

HOSPITAL INSURANCE

Hospice services covered by Medicare

- Nursing services
- Doctors' services*
- Drugs, including outpatient drugs for pain relief and symptom management
- Physical therapy, occupational therapy and speech-language pathology
- Home health aide and homemaker services
- Medical social services
- Medical supplies and appliances
- Short-term inpatient care, including respite care
- Counseling

*If a patient's attending physician is not working for the hospice program, Medicare medical insurance will continue to pay for his or her services in the same way it usually pays for other doctors' services.

What Medicare Covers

MEDICAL INSURANCE — COVERED SERVICES

Medical insurance covers *doctors' services* regardless of where they are furnished—in the doctor's office, a clinic, a hospital or skilled nursing facility or in your home.

It covers *outpatient hospital services*, either in the hospital outpatient department or in the emergency room, both for diagnosis and for treatment services.

Under certain conditions, Medicare can pay a special rate for certain surgical procedures performed in Medicare-certified ambulatory surgical centers. Also, Medicare can help pay for outpatient services received from a comprehensive outpatient rehabilitation facility (CORF).

It covers services by *independent clinical laboratories* for diagnostic testing

and covers all medically necessary home health visits for people who do not have Medicare hospital insurance.

Medical insurance also covers diagnostic X-ray and radiation therapy services, physical therapy services in a doctor's office, a clinic and, to a limited degree, in a physical therapist's office or in your home. It covers pneumococcal vaccinations, prosthetic devices, purchase or rental of durable medical equipment for use in your home, certain ambulance services and a number of other medical supplies and equipment.

The combination of medical insurance and hospital insurance provides a broad and comprehensive package of health insurance protection.

What Medicare Covers

MEDICAL INSURANCE

What Is Covered

- Doctors' Services
- Outpatient Hospital Services
- Laboratory Services
- Certain surgical procedures performed in certified ambulatory surgical centers
- X-Ray and Radiation Therapy Services
- Home Health Visits
- Physical Therapy and Speech Pathology Services
- Pneumococcal Vaccinations
- Hepatitis B Vaccinations
- Durable Medical Equipment
- Limited Ambulance Services
- Prosthetic Devices and Other Medical Supplies and Equipment
- Certain services in Comprehensive Outpatient Rehabilitation Facilities (CORFs)

What Medicare Covers

MEDICAL INSURANCE — WHAT MEDICARE PAYS

Medical insurance pays 80 percent of the amount approved by Medicare for covered services after an annual \$75 deductible is met (1985 amount). The \$75 deductible must represent covered services and is based on the approved charges rather than actual bills.

The amounts approved by Medicare are updated every July 1 to try to keep pace with changes in medical care prices. Because this update is based on price information collected during the preceding year*, and because price changes during the current period of high inflation have been more frequent than in the past, the amount approved by Medicare, on which medical insurance benefits are based, is often less than the charges doctors and suppliers will bill

you. As a result, 80 percent of the approved charges will often be less than 80 percent of your bill from a doctor or supplier.

As we will note later, this difference between the actual charge to you and the amount approved by Medicare on which Medicare benefits are based is one of the major gaps in Medicare. Most private insurance policies do not cover this additional cost. Where your doctor or supplier takes an "assignment," discussed in the next section, you can avoid this additional expense.

*For example, the updated amounts approved by Medicare on July 1, 1985, are based on prices which were in effect during calendar year 1984.

What Medicare Covers

MEDICAL INSURANCE

What Medicare Pays

- 80 percent of the approved charge after \$75 annual deductible is met (1985 amount)
 - Approved charges*—updated every July 1, based on actual charges by doctors and suppliers *in your area* during the *preceding* calendar year
 - Approved charges—often *less* than what your doctor or supplier currently charges because of time “lag” and inflation

What Medicare Covers

MEDICAL INSURANCE — ASSIGNMENT

The Medicare program has no legal authority to limit the amounts doctors and suppliers may charge Medicare beneficiaries. But the law authorizes a voluntary arrangement called "assignment." Under this arrangement, a doctor or supplier can agree to file the claim and accept the Medicare payment directly from the Medicare program, but as a condition of such direct payment, must also agree to accept Medicare's approved charge as the total charge for the services covered by the assignment.

If your doctor or supplier accepts assignment, this means that he or she can charge you only for any of the \$75 annual deductible not yet met, (1985 amount), for 20 percent of the remaining approved charges and, of course, for any services not covered by the program. In an assignment case, you cannot be charged

for any difference between the amount approved by Medicare and the actual charge the doctor or supplier would otherwise have billed to you.

Assignment is a case-by-case choice. Some doctors and suppliers always take assignment. Some never accept assignment. Most will accept assignment on some claims, but not on others. Because it will usually be to your financial advantage, you should always ask. (Physician/Supplier Assignment Rate Lists, which show the approximate percentage of claims on which physicians and suppliers in your area accepted assignment in the previous calendar year, are now available for review in all local Social Security offices and all State and Area Agencies on Aging.)

Here is an example, assuming you have met your \$75 deductible (1985 amount):

	<u>Surgery: Actual Charge</u>	<u>Medicare Approved Charge</u>	<u>Medicare Pays</u>	<u>You Are Responsible For</u>
Doctor <i>Accepts</i> Assignment	\$500	\$400	\$320 (80% of approved charge)	\$80 (20% of approved charges)
Doctor <i>Does</i> <i>Not Accept</i> Assignment	\$500	\$400	\$320 (80% of approved charge)	\$180 (difference between actual charge and ap- proved charge)

What Medicare Covers

MEDICAL INSURANCE

When Your Doctor or Supplier Accepts Assignment

- Medicare payment is sent directly to doctor or supplier
- You are responsible for any of the \$75 annual deductible not yet met (1985 amount)
 - 20 percent of the approved charge
 - Any items or services not covered by Medicare
- Your total payment to the doctor or supplier cannot exceed the amount approved by Medicare

What Medicare Covers

MEDICAL INSURANCE — NONASSIGNMENT

When the doctor or supplier does *not* agree to an assignment, you must file the medical insurance claim and the Medicare payment is sent to you.

The medical insurance payment will be 80 percent of the approved charge for the covered services you receive after your \$75 annual deductible is met (1985 amount). You are responsible for the entire amount the doctor or supplier has billed you (See page 24).

If the difference between the approved charge and the actual charge you are billed is large enough to cause a hardship, you should consider discussing the difference with the doctor or supplier. Some may be willing to adjust their charge in your favor or, at least, work out a payment arrangement over a longer period than usual.

What Medicare Covers

MEDICAL INSURANCE

When Your Doctor or Supplier Does Not Accept Assignment

- Medicare payment sent directly to you
- You are responsible for the entire bill
- You receive Medicare payment for 80 percent of the amount approved by Medicare for covered services after the \$75 annual deductible is met (1985 amount)

What Medicare Does Not Cover

THE THREE GAPS IN MEDICARE

There are three major categories of health care expenses not covered by Medicare that represent gaps. They are (1) the Medicare deductibles and copayments for the services Medicare covers; (2) the medical items and services that Medicare does not cover at all, and (3) in nonassignment cases, the difference between the amount approved by Medicare and the actual charge for covered services by doctors and suppliers under the medical insurance program.

We will discuss these three gaps in greater detail in the next few sections. If you decide you want and need added

protection, your choice of a private health insurance policy should be based on a careful consideration of how well it fills the gaps in Medicare that you feel you should be insured against. The different types of private insurance you can buy offer different ways of filling some, but not all, of these gaps. As we will discuss later, the more you know about what Medicare covers and what it does not cover, and how these different kinds of private health insurance relate to the gaps in Medicare, the better choice you will make for your own individual situation.

Medicare Does Not Cover:

THE THREE GAPS

- (1) Medicare deductibles and copayments.
- (2) Noncovered items and services.
- (3) Charges exceeding the amount approved by Medicare.

What Medicare Does Not Cover

DEDUCTIBLES AND CO-PAYMENTS

The deductibles and copayments under Medicare are specific money amounts for covered services that the program does not pay, or in the case of blood, a specific initial quantity of blood for which you can be charged before Medicare assumes all or part of the additional costs.

In the hospital insurance program, there are basically 5 fixed amounts which the program does not pay even though the services are otherwise covered. These are: (1) the *\$400 inpatient hospital deductible* that you pay on your first admission to a hospital in each benefit period; (2) the *\$100 a day* for the 61st through the 90th day of inpatient hospital care in each benefit period; (3) the *\$200 a day* for each "reserve" day you use for inpatient hospital care after 90 days of such care in a benefit period; (4) the *\$50 a day* for the 21st through the 100th day in each benefit period for care in a skilled nursing facility and, (5) the *first 3 pints of whole blood or units of*

packed cells you use in each benefit period in connection with covered hospital insurance services. The money amounts in the hospital insurance program are subject to change at the beginning of each calendar year, based on changes in hospital costs.

In the medical insurance program there are 3 such fixed amounts. These are (1) the *first \$75 of covered medical expenses*—the 1985 annual medical insurance deductible; (2) *20 percent* of the amount approved by Medicare for covered services and, (3) the *first 3 pints or units of blood* you use in a calendar year in connection with covered medical insurance services. This blood deductible is separate from the 3 pint blood deductible in the hospital insurance program—one cannot be used to meet the other.

The money amounts in the medical insurance program are established by law and can only be changed if the Medicare law is amended.

Medicare Does Not Cover:

DEDUCTIBLES AND COPAYMENTS

(1985 Amounts)

Hospital Insurance

- \$400 for the first 60 days of inpatient hospital services in a benefit period (the inpatient hospital deductible)
- \$100 a day for the 61st through 90th day of inpatient services in a benefit period
- \$200 a day for each "reserve" day used
- \$50 a day for the 21st through 100th day in a benefit period for inpatient care in a skilled nursing facility
- The first 3 pints or units of blood in a benefit period

Medical Insurance

- The first \$75 of approved charges for covered services (the 1985 medical insurance deductible)
- 20 percent of the approved charges for all covered services above the deductible
- The first 3 pints or units of blood in a calendar year

What Medicare Does Not Cover

NON-COVERED ITEMS AND SERVICES

The gap area represented by items and services not covered at all under Medicare involves the largest out-of-pocket costs for Medicare beneficiaries. It is also an area in which *few* private health insurance policies offer significant additional protection.

The major services not covered by Medicare hospital insurance are: (1) services after 150 days of inpatient hospital care in a benefit period (after 90 days if you have used all your "reserve" days); (2) services after 100 days of inpatient skilled nursing facility care in a benefit period; (3) nursing home care in other than a skilled nursing facility, or noncovered care in a skilled nursing

facility and (4) a private room in a hospital or skilled nursing facility (unless medically necessary), or private duty nursing in either facility.

The major services not covered by Medicare medical insurance are: (1) drugs and medicines you buy yourself; (2) eyeglasses (except prosthetic lenses after cataract surgery) and routine eye examinations; (3) hearing aids and routine hearing loss examinations and, (4) dental care.

Neither hospital insurance nor medical insurance covers services which are not medically necessary, nor services in a foreign country (with some exceptions for Canada and Mexico).

Medicare Does Not Cover: NONCOVERED ITEMS AND SERVICES

Hospital Insurance

- More than 150 days of inpatient hospital care in a benefit period (over 90 days if you have used all your "reserve" days)
- More than 100 days of inpatient skilled nursing facility care in a benefit period
- Nursing home care in other than a skilled nursing facility
- Private duty nursing
- Private room (unless medically necessary)

Medical Insurance

- Drugs and medicines you buy yourself
- Eyeglasses (except after cataract surgery)
- Hearing aids
- Dental care

Hospital Insurance/Medical Insurance

- Care outside the United States (except under certain conditions)
- Services and supplies that are not medically necessary

What Medicare Does Not Cover

CHARGES THAT EXCEED THE AMOUNT APPROVED BY MEDICARE

As we discussed earlier, the approved charge on which Medicare bases its payments under the medical insurance program is often less than the amount billed to you by a doctor or supplier. In fact, in fiscal year 1983 about 80 percent of all allowed claims under the medical insurance program were reduced because the billed amount exceeded the Medicare approved charge.

Of the total money amount reduced, almost one-half was for unassigned claims. As you remember, when a claim

is unassigned, the beneficiary, in addition to paying the deductible and copayment, is responsible for paying the difference between the actual charge and the approved charge. This large money amount for which beneficiaries are responsible in unassigned medical insurance claims is a major gap.

Most private health insurance policies do not cover these charges. Whenever possible, therefore, you should try to secure doctor and supplier services on an assignment basis.

Medicare Does Not Pay For:

CHARGES THAT EXCEED APPROVED CHARGES

- Over 80 percent of all allowed Medicare claims in the medical insurance program in fiscal year 1983 were reduced because the billed amount exceeded the approved amount
- The total amount reduced was over \$5.6 billion
 - Of this, almost half was for unassigned claims—a major out-of-pocket expense for the elderly
 - Few private insurance policies cover these charges

Do You Need Private Health Insurance?

TWO IMPORTANT FACTS

Whether you need private health insurance in addition to your Medicare protection is a decision that only you can make. While Medicare covers a very substantial array of health care services, Medicare does not offer complete health insurance protection. Private health insurance, if it is carefully chosen, and if you can afford the additional expense, can help fill *some* of the gaps.

Most experts feel that if you can afford it, it is a good investment to buy the additional protection that private health insurance can provide, so long as you shop carefully and buy one of the better policies that offers you the kind of additional help you think you need most. But it is important for you not to be

misled by the claims of a private insurer or a private insurance agent that you will be "fully" protected by buying private insurance.

One very important caution—if you are eligible for Medicaid, which is a health care program administered by the States which helps pay medical expenses for low income people, do not purchase private health insurance until you discuss it with your State Medicaid Agency or someone else who understands your financial situation. The combination of Medicare and Medicaid pays almost all of your essential medical costs and those services that neither program covers are almost never covered by private health insurance policies.

Do You Need Private Health Insurance?

TWO IMPORTANT FACTS

- Private health insurance can help you fill some, but not all of the Medicare gaps
- If you are eligible for Medicaid, do not purchase private health insurance without advice. The combination of Medicare and Medicaid pays almost all essential medical costs

What Kinds of Private Health Insurance Can You Buy?

BASIC TYPES

Private health insurers selling policies to add to your Medicare protection have designed a wide variety of policies to suit different needs and preferences. There are 7 basic types of such insurance.

They are: (1) continuation or conversion of a policy you have when you reach 65; (2) Medicare Supplement policies, which are specifically designed to pay some of the money amounts that Medicare does not pay for covered services; (3) catastrophic or major medical expense policies, which are designed for high expense situations and do not begin paying until a large deductible is met; (4) Health

Maintenance Organizations (HMOs), from which you purchase health care services directly for a fixed, periodic advance payment; (5) hospital indemnity policies, which pay cash amounts for each day of inpatient hospital services; (6) nursing home policies, which pay cash amounts for each day of covered nursing home care; and, (7) specified disease policies, which pay only when you need treatment for the disease insured against.

We will discuss each of these types of insurance in greater detail in the following section.

What Kinds of Private Health Insurance Can You Buy?

BASIC TYPES OF PRIVATE HEALTH INSURANCE

- Continuation or conversion of pre-65 coverage
- Medicare Supplement policies
- Catastrophic or major medical expense
- Health maintenance organizations (HMOs)
- Limited Coverage Policies:
 - Hospital indemnity
 - Nursing home coverage
 - Specified disease coverage

What Kinds of Private Health Insurance Can You Buy?

CONTINUATION OR CONVERSION OF PRE-65 COVERAGE

Many people, upon reaching age 65, already have private insurance coverage, either privately purchased, or, more frequently, in connection with their current employment. In these situations, most insurers will either permit continuation of coverage or conversion to a modified coverage taking your new Medicare coverage into account. If your prior insurance was partly funded by your employer, that premium sharing can sometimes continue in connection with your after-65 coverage.

While your decision to continue or convert existing coverage should be primarily based on how well such insurance will meet your individual needs, most experts rate this option as one of the best buys in additional health insurance protection for a number of reasons. First, you have uninterrupted coverage. Second, continued or converted coverage usually requires no medical history since that has already been established, so that there are no pre-existing condition exclusions. Third, if the prior policy was based on your employment, the continued or converted coverage is usually based on group premium rates, which are often lower than the premium rates for individually

purchased policies. And, of course, if your employer continues to share in the premium costs, your premium costs will be significantly reduced. You should ask your employer for a written outline of your post-retirement health insurance benefits.

One note of caution, however. If you have a spouse under 65 who was covered under the prior policy, make sure you know what effect your continued or converted coverage will have on his or her insurance protection.

A Special Note for Workers Over 65:

An amendment to the Medicare law which became effective January 1, 1983 requires all employers of 20 or more people to offer employees and their spouses age 65 through 69 the same health insurance coverage they offer their younger employees. If workers in this age category choose their employer's plan, Medicare becomes the secondary payer. If the worker declines the employer plan, Medicare is the primary payer. For more information about this amendment contact your employer's personnel office or obtain a copy of *Medicare and Employer Health Plans* from the nearest Social Security office.

What Kinds of Private Health Insurance Can You Buy?

CONTINUATION OR CONVERSION OF PRE-65 COVERAGE

- No waiting periods
- No pre-existing condition exclusions
- No medical data required
- Often includes spouse
- Employer often pays part of premium

What Kinds of Private Health Insurance Can you Buy?

MEDICARE SUPPLEMENT POLICIES

Medicare supplement policies primarily cover some or all of the deductible and copayment money amounts Medicare does not pay. Sometimes they offer extensions of coverage for the services Medicare covers only up to certain maximums, such as the number of covered hospital days in a benefit period. The essential characteristic of a Medicare supplement policy is that it usually covers only the same services that Medicare covers, but fills in some or all of the Medicare nonpayment gaps for those services.

Some Medicare supplement policies add additional coverages for services Medicare does not cover at all, such as drugs and medicines, but this is the

exception rather than the rule. Most Medicare supplement policies do not cover the difference between actual charges and the amount approved by Medicare for unassigned Medicare medical insurance claims for services by doctors and suppliers.

Many experts feel that Medicare supplement policies offer good additional protection to Medicare beneficiaries if they cover copayments under both Medicare hospital and medical insurance and offer extensions of inpatient hospital day limits under Medicare. If, in addition, the policy also covers drugs and medicines to some degree, it offers even more protection.

What Kinds of Private Health Insurance Can You Buy?

MEDICARE SUPPLEMENT POLICIES

- Mainly cover only services *also* covered by Medicare
- Pay some or all deductibles and copayments Medicare does not pay
- May offer additional coverages
 - Additional days of inpatient hospital and skilled nursing facility care
 - Drugs and medicines to some degree

What Kinds of Private Health Insurance Can You Buy?

CATASTROPHIC OR MAJOR MEDICAL EXPENSE

Some people may feel that they can afford Medicare deductibles and copayments or, because they have limited funds to spend on insurance premiums, may feel that they would rather insure against major expenses than against the smaller, periodic Medicare deductible and copayment costs.

Catastrophic or major medical expense policies are designed for such preferences. Generally, a catastrophic or major medical expense policy will have a high initial deductible such as \$4,000 or \$5,000, before it begins paying. Thereafter, however, it will pay up to very large amounts, such as \$250,000, for the service it covers.

Very few catastrophic or major medical policies are available to people over 65 on an individual purchase basis. Most such policies are continuations of pre-65 coverage or are available only on the basis of membership in a group or association. Where such policies are available and, of course, depending on the quality of the specific policy, catastrophic or major medical expense policies may be a good buy for those who feel that their greatest insurance priority is to protect themselves and their families from the high costs of an extended illness requiring expensive medical care.

What Kinds of Private Health Insurance Can You Buy?

CATASTROPHIC OR MAJOR MEDICAL EXPENSE

- Usually covers health care expenses after a large deductible is met (generally \$4,000–\$5,000)
- Excellent coverage for people who can afford Medicare deductibles and copayments out-of-pocket, or who have good basic insurance coverage
- Not widely available after 65—usually continuation of pre-65 coverage

What Kinds of Private Health Insurance Can You Buy?

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

If there is a Health Maintenance Organization (HMO) in your area that is participating in Medicare, you may wish to consider this option. (Some Medicare-participating HMOs are called Competitive Medical Plans or CMPs.) For people with Medicare, membership in a HMO offers additional protection similar to the purchase of a Medicare Supplement policy.

An HMO is an organization that offers direct health services from its own doctors, hospitals, and other health delivery resources in return for a membership fee paid in advance, usually on a monthly basis. In effect, it both insures and provides health care services. It is, in short, a prepaid health care system.

When you join a Medicare-participating HMO, in addition to your Medicare Part B premium you also pay an HMO membership premium to cover the Medicare deductible and copayment costs, so that you receive all Medicare covered services without any additional cost. This means that, since all your Medicare covered services are prepaid under your HMO membership premium, you do not have to file any claims.

Many HMOs offer health care services in addition to those covered by Medicare, such as additional days of care or coverage of drugs and medicines. Some HMOs provide the additional services without increased premiums; others may charge a small added fee.

What Kinds of Private Health Insurance Can You Buy?

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

(HMOs)

- Combined health insurance and health care delivery arrangement
- In an HMO participating in Medicare—
 - You pay a membership fee
 - All services covered by Medicare are furnished through the HMO
 - Membership fee covers Medicare deductibles and coinsurance
 - Services are prepaid; no claims to file

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE - HOSPITAL INDEMNITY

Hospital indemnity policies are a limited coverage type of policy in that they offer protection only for inpatient hospital care.

These policies usually pay a fixed amount on a per-day basis, for example, \$30 a day of inpatient hospital occupancy. Coverage may begin on the first day of hospitalization or on a later date. Some policies have a maximum number of days or a maximum payment amount. Some do not become effective immediately, but require a 3-day or more waiting period. Many exclude coverage for pre-existing conditions for one or two years or exclude certain pre-existing conditions permanently.

Generally, a hospital indemnity policy will pay the specified daily amount regardless of any other health insurance coverage you have. Many experts feel

that , *if* you are insured with a good general coverage, *basic* policy in addition to Medicare, a hospital indemnity policy can sometimes be valuable additional protection for those who can afford it. This is because it pays cash during a hospital stay that can help in meeting the additional personal and family expenses associated with a hospital stay. Other experts, however, note that the average hospital stay for Medicare beneficiaries is approximately 10 days. Further, they observe that the average beneficiary after reaching age 65 has three or four hospital admissions in his or her lifetime. They conclude, therefore, that a hospital indemnity policy is not as good an insurance investment as a more comprehensive supplementary policy would be.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE

Hospital Indemnity Policies

- Per day cash payments
- Pay only for actual days in hospital
- Often do not begin on first day of hospitalization
- Often have maximum number of days or maximum payment amount for single hospitalization
- Do not increase per day payments with inflation
- May have pre-existing condition exclusions

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE - NURSING HOME COVERAGE

Some private health insurers sell what are advertised as "nursing home" policies. These policies generally pay a per-day amount for each inpatient day of care in a "nursing home." Some policies may also cover the Medicare coinsurance amounts from the 21st through the 100th day in a skilled nursing facility, but may deny this further coverage if Medicare determines that your medical condition no longer requires this level of care. Before buying this kind of limited coverage policy it is extremely important that you fully understand exactly what is covered and what is not covered.

Nursing homes are classified into three broad types: (1) skilled nursing facilities, primarily furnishing medical treatment and rehabilitative services; (2) intermediate care facilities, primarily furnishing personal care and medical management services, but also having skilled nursing personnel and rehabilitative services available on an as-

needed basis; and (3) residential or personal care facilities, primarily furnishing personal support services, such as help in eating, dressing, bathing, and taking routine medications.

Most "nursing home" policies on the market cover only acute, post-hospital care in a *skilled* nursing facility. Many elderly people who need nursing home care are in intermediate or personal care facilities, because their primary need is for assistance and support services resulting from their increasing inability to care for themselves in their own homes, even with the help of other family members. Many people buying "nursing home" policies, believing that they were protecting themselves against the day when they could no longer care for themselves at home, have been disappointed to discover that their policy does not cover "nursing home" care in an intermediate or personal care facility, or custodial care in a skilled nursing facility.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE

Nursing Home Coverage Policies

- Usually pay per-day amounts
- Rarely cover care in other than skilled nursing facilities
- Most U.S. nursing homes are *not* skilled nursing facilities
- Rarely cover care that is primarily custodial—care mainly to meet personal care needs such as bathing, feeding, dressing, taking medicine
- Most nursing home care needed by the elderly is custodial—i.e., personal care

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE - SPECIFIED DISEASE POLICIES

A few insurers offer policies which are limited to treatment for a specific illness or a group of specific diseases. The most common type of policy in this area is cancer insurance.

Most experts caution purchasers to examine this kind of insurance very carefully.

First of all, Medicare covers much of the care needed by people with cancer and other diseases covered by a specific disease policy. Sometimes a specified disease policy has what is called a "coordination of benefits" clause. It does

not pay, or pays far less than expected, when another insurer, such as Medicare, is covering the same costs.

Secondly, many of these policies have very restrictive conditions regarding the type of treatment covered and in what types of facilities covered treatment can be reimbursed.

Thirdly, many of these policies have low maximum payment amounts which are quickly exhausted in the event of a long treatment period. Some States prohibit the sale of specified disease policies.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE

Specified Disease Policies

- Usually cover single type of disease such as cancer or heart disease
- Usually have maximum payment amounts for specific types of treatment
- Often have restrictive conditions
- Prohibited in some States

Hints For Buying Private Health Insurance

SHOPPING HINT #1

Do Not Buy More Policies Than You Need

- Many policies have a “coordination of benefits” clause—policy will not pay when another insurer pays or each insurer will pay part of the costs, not to exceed total actual cost
- Duplicate coverage is costly—often means multiple premiums with no greater protection than a single good policy

Hints For Buying Private Health Insurance

SHOPPING HINT #2

Check For Pre-Existing Condition Exclusions and Waiting Periods

Be sure you know:

- When new policy begins paying
- If any medical conditions are permanently excluded or not payable until a future date
- You have this information in writing

Hints For Buying Private Health Insurance

SHOPPING HINT #3

Be Careful About Replacing Existing Coverage

- Usually a waiting period
- Your current medical condition may affect your new coverage
 - However*, do not keep an inadequate policy just because you have had it a long time
 - If you do replace it, keep old policy in force until new one becomes effective

Hints For Buying Private Health Insurance

SHOPPING HINT #4

Be Aware of Maximum Benefits

- Many policies have maximum payment amount under entire policy or for specific treatments. Some have maximum number of days or visits
- Get the maximums in writing to see if they meet your needs

Hints For Buying Private Health Insurance

SHOPPING HINT #5

Check Your Right To Renew

- Avoid policies "renewable at company option"
Company could cancel your individual policy for any reason at end of policy year or when premium comes due

Hints For Buying Private Health Insurance

SHOPPING HINT #6

Beware of the "Government Look"

- Implied government affiliation or endorsement
- Advertising literature designed to look "Governmental"—
 - Social Security envelope size
 - Official-looking seal
 - Correspondence begins with "Dear Medicare Member"

REMEMBER

- No private insurance company selling insurance to add to Medicare is affiliated with or endorsed by the Federal Government
- A Federal seal on a policy does not mean government endorsement

Hints For Buying Private Health Insurance

SHOPPING HINT #7

Take Your Time

- Don't be "high pressured"
- Beware of "last chance to enroll" statements. Ethical salespeople never "high-pressure" you
- Shop carefully and compare policies for what they cover and what they cost
- Buying insurance is an important decision. Take enough time to feel confident about your choice. Consult others if you can before you buy

Hints For Buying Private Health Insurance

SHOPPING HINT #8

Beware of "Scare Tactics"

- Agent or advertising literature describes extreme situations to frighten purchaser
 - Exaggerated expenses
 - Exaggerated likelihood of illness

Remember

- Less than 2 percent of the elderly exhaust their Medicare inpatient hospital benefits in any given year
- Less than 6 percent of the elderly are in nursing homes
- Few private health insurance policies cover services Medicare does not cover

Hints For Buying Private Health Insurance

SHOPPING HINT #9

Do Not Withhold Medical Information

- Withholding medical information on a policy application may lead to nonpayment for a later claim
- Never believe salespersons who say you don't have to furnish such information when the application requests it, or say they will fill in that information later

Hints For Buying Private Health Insurance

SHOPPING HINT #10

Get a Written Outline of Coverage

- Always ask for a written description of the policy you are considering buying—in simple language
- A company selling a good policy will always provide a simplified description of what they are offering for sale
- Read it carefully

Hints For Buying Private Health Insurance

SHOPPING HINT #11

Do Not Pay Cash

- Always pay by check, money order, or bank draft made out to the insurance company—never to the agent or anyone else
- Always write down the name, address and telephone number of the agent or insurance company, so you can follow up if there is any delay in getting your policy

Hints For Buying Private Health Insurance

SHOPPING HINT #12

Make Sure There Is A "Free Look" Provision

- Most reputable insurance companies give you at least 10 days after you receive your policy to look it over. During that time, if you decide you don't want it, you can return it for a full refund of your premium
- Beware of any insurance policy that is on a "take it or leave it" basis and does not give you a grace period to change your mind

Hints For Buying Private Health Insurance

SHOPPING HINT #13

Be Aware of Illegal Sales Practices

- Federal criminal penalties can be imposed against a company or agent who
 - suggests they represent the Medicare program or any Federal agency
 - knowingly sells you a policy which duplicates Medicare coverage or any private health insurance you already own that will not pay duplicate benefits
- Contact your State Insurance Department for further information or to report misleading practices

For Further Information

**Health Care Financing Administration
(HCFA)**
Regional Office

Name:

Address:

Telephone: ()

State Insurance Department

Name:

Address:

Telephone: ()

State Medicaid Agency

Name:

Address:

Telephone: ()

Other

Using the Medicare/Private Insurance Checklist

The Medicare/Private Health Insurance Checklist for the major types of supplemental insurance is designed to help you quickly determine how well a particular policy will meet your health insurance needs.

In Part I, **Medicare Supplement Policies**, by checking the “yes” and “no” blocks and filling in the blocks showing how much the policy pays, you will be able to see exactly how well the listed “gaps” in Medicare coverage are met by the policy you are considering.

In Part II, **Hospital Indemnity Policies**, the answers to the questions will help you to determine whether the particular policy offers as much protection as you are seeking in this limited area of coverage. The questions in Part III, **Nursing Home Policies**, will help you determine exactly what kinds of nursing homes are covered by the policy and under what conditions the policy will pay.

I MEDICARE SUPPLEMENT POLICIES

Use this section for insurance policies that promise to pay “all the expenses that Medicare does not pay” or which promise to pay “all the gaps in Medicare.” By checking the “yes” and “no” blocks for each of the listed items that Medicare does not cover and answering the other questions, you will be able to see at a glance just how well the proposed policy can help you meet the health care expenses Medicare does not pay.

II HOSPITAL INDEMNITY POLICIES

Use this section for insurance policies that promise to pay “cash” for each day you are a hospital inpatient. Remember that hospital indemnity policies always pay on a per-day basis. Do not be misled by policies which advertise, for example, “\$1500 per month.” That is only about \$50 a day and the policy will not pay for any days you are not in the hospital. In addition, be sure you know on what day of your stay the daily payments begin and whether there is a maximum number of days or total amount that can be paid.

III NURSING HOME POLICIES

Use this section for insurance policies that promise to pay for “nursing home” care. Nursing home policies are usually very limited and exclude care that most people associate with the phrase “nursing home.” Be sure you know what kind of nursing home care is covered. Most nursing home policies cover only medically necessary care in a skilled nursing facility, and do not cover custodial or long-term care in either a skilled nursing facility or other type of nursing home.

NOTE: Examine specific disease policies, such as Cancer Insurance, very carefully. We suggest you seek professional advice before purchasing this type of policy.

I. Medicare Supplement Policies

NAME OF COMPANY _____ Premium \$ _____

POLICY # _____

NOT COVERED BY MEDICARE (1985 figures—Subject to Change in 1986)	COVERED BY PROPOSED POLICY		WHAT DOES PROPOSED POLICY PAY
	YES	NO	
\$400 for the first 60 days of inpatient hospital services in a benefit period (the inpatient hospital deductible)			
\$100 a day for the 61st through 90th days of inpatient hospital services in a benefit period			
\$ 200 a day for inpatient hospital services for each "reserve" day used (can be used up to a total of 60 days, whenever you need more than 90 days in a benefit period)			
Over 150 days of inpatient hospital services in a benefit period (over 90 days if you have used all your "reserve" days)			
\$50 a day for the 21st through 100th day in a benefit period for inpatient services in a skilled nursing facility			
Over 100 days of inpatient skilled nursing facility care in a benefit period			
Nursing home care in other than a skilled nursing facility			
Private room in a hospital or skilled nursing facility (except when medically necessary)			
Private duty nurses in a hospital or skilled nursing facility			
The first 3 pints of blood under either Medicare hospital or medical insurance			
The first \$75 of doctor bills and other medical services and supplies under Medicare medical insurance (the medical insurance annual deductible)			

Medicare Supplement Policies (cont.)

NOT COVERED BY MEDICARE (1985 figures—Subject to Change in 1986)	COVERED BY PROPOSED POLICY		WHAT DOES PROPOSED POLICY PAY
	YES	NO	
After the first \$75, 20 percent of the amount approved by Medicare for:			
Doctors' bills			
Outpatient hospital services			
Outpatient physical therapy and speech pathology services			
Other medical services and supplies			
Charges above the amount approved by Medicare in nonassignment cases			
Drugs and medicines you buy yourself			
Eyeglasses (except after cataract surgery)			
Hearing aids			
Dental care			
Medical care outside the United States (except under certain conditions in Canada and Mexico)			
Are there any additional benefits the proposed policy pays? YES ☐ NO ☐			
If yes, describe _____			

a. Is there a pre-existing condition exclusion? YES ☐ NO ☐

If yes, what conditions are excluded and for how long? _____

b. Is there a waiting period before policy pays benefits? YES ☐ NO ☐

If yes, when does the policy begin paying benefits? _____

II. Hospital Indemnity Policies

NAME OF COMPANY _____ PREMIUM _____

POLICY # _____

- a. What is the daily payment rate? \$ _____ per day
- b. On what day of a hospital stay do payments begin? _____
- c. What is the maximum number of days the policy will pay? _____
- d. Is there a maximum payment provision? If yes, what is the maximum amount? _____ YES ☐ NO ☐
- e. Are there any excluded illnesses? If yes, describe. YES ☐ NO ☐

- f. Are there any benefits in addition to the daily payment rate? If yes, describe. YES ☐ NO ☐

III. Nursing Home Policies

NAME OF COMPANY _____ PREMIUM _____

POLICY # _____

- a. Does the policy cover care in facilities other than skilled nursing facilities YES ☐ NO ☐
If yes, what other kinds of nursing homes?

- b. Does the policy cover your stay in a skilled nursing facility or other nursing home when the care you need is primarily custodial care, that is, mainly personal care, such as help in feeding, dressing, getting in and out of bed, and taking medicine? YES ☐ NO ☐
If yes, under what conditions and for how long will the policy pay for such care?

- c. Are there any excluded illnesses? If yes, describe. YES ☐ NO ☐

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